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'Conversations at the frontier of dreaming' Ogden.

Chapter 6

Re-minding the body.

There is little in the practice of psychoanalysis more perplexing (or more interesting) to me than the question of how experiences in analysis facilitate the healthy development of the patient's sense of being alive in his or her body. In health, the experience of being bodied and the experience of being minded are inseparable qualities of the unitary experience of being alive. Achieving this kind of sense of aliveness is particularly problematic when early childhood experience (whether precipitated by constitutional hypersensitivity, inadequate maternal provision, or trauma) has led the individual to create a pathological form of mindedness that is disconnected from experiences in the body. Under such circumstances, thinking tends to be anxiously preoccupied with the achievement of absolute self-sufficiency: in the realms of both bodily sensations and internal and external object relations (Gaddini 1987; McDougall 1974; Tustin 1986; Winnicott

1949, 1952). This goal is pursued by hypertrophied mental activity designed to anticipate, understand, explain, measure, create, and annihilate (and in all these ways omnipotently control) everything that happens in the experience of the body, as well as in relationships to external and internal objects. This sort of defensive mental activity feels disconnected from the body: sensations stemming from the body so threaten to overwhelm the individual that not only his sanity, but his very being, are felt to be under siege.

The analysis of a patient who had been both neglected and traumatized in early childhood helped me to gather impressions that had been accruing over the course of many years of analytic work. In the fragment of the analysis that I will present, the important interventions were not preplanned. In fact, they came as a surprise to me, and I find them particularly interesting and in need of scrutiny for that reason. I had in these instances a sense of "I-ness" (a feeling of who I was in that moment with that patient) that was reflected as much in the sound of my voice (which was for me a very sensory experience) as in the content of what I said. This "I-ness" was not entirely known to me before I heard it in my voice and felt it in my body. It was a voice highly personal to me, and at the same time unmistakably the product of the shared unconscious experience generated by the patient and me in the course of the analysis.

Integrally connected with this sense of "I-ness," which was brought to life in the medium of voice, was a form of intervention that also felt new to me, although

not discontinuous with my ongoing experience of who I am as an analyst. In the period of analysis that I will discuss, I found myself telling the patient an imaginary present-day story (based on the patient's history and the history of the analysis). This story, and the patient's experience of my telling it to him, served to make available to him symbols and a human connection with me that he could use to project himself and me into the past. In this way, he succeeded in humanizing what had been for him an inhumane, solitary, inarticulate, unthinkable set of psychological and bodily events.

Clinical Illustration: A Man with His Back to the Wall

Mr. S, a highly successful thirty-eight-year-old attorney, consulted me because he felt he was fading away as a person, and—even more disturbing to him—he increasingly did not seem to care. Over a period of years he had felt himself gradually withdrawing from his family, his work, and his colleagues. As the analysis proceeded, it became clear that such feelings of withdrawal were by no means new; they had permeated his life from as far back as he could remember. Mr. S held himself responsible for the failure of his previous marriage and for the problems in his current one. He described himself as "constitutionally incapable" of ever admitting he is wrong. This "blind stubbornness" prevented the healing of any rift in a relationship, so the discord in virtually every relationship he had eventually became so severe as to lead to its demise.

Since my interest in this chapter is in exploring a sequence of interventions and responses that took place in the fourth year of Mr. S's analysis, I will offer only a schematic overview of the analytic events leading to the sessions I will discuss here. During the first years of our work together, the analytic relationship was marked by intensely charged efforts on the part of Mr. S to engage me in intellectual "jousting." He would take a "devil's advocate" position on virtually any topic, doggedly defending one side or the other of a complex matter. (Which side of the argument he adopted seemed arbitrary—it was the experience of arguing that mattered.) In this period of our work, the patient and I in the transference-countertransference relied heavily on the largely unconscious defensive fantasy that feats of the intellect (in "combat" situations) had the power to protect him (and me) from painfully out-of-control bodily sensations, as well as from the terrifying aspects of internal and external reality that threatened to overwhelm him (and me). This work led Mr. S and me to view his aggressive "stubbornness" as representing (at least in part) an unconscious attempt to maintain his sanity in the face of what felt like impending psychic fragmentation.

As the work progressed, Mr. S fearfully and shamedly told me (in bits and pieces that were both confused and confusing) about a series of sexual molestations that he had experienced in his childhood. These molestations had occurred over a period of two or three years, beginning when Mr. S was three or four. Since he had never told anyone about them as they were occurring, he did

not know for sure how old he was at the time, or how long they went on. His feeling/belief that the molestation had in fact occurred was based on fragmentary but vivid memories of the experience, and on a very brief discussion many years later with his older brother. In this conversation, Mr. S learned that his brother had been molested by the same man, a next-door neighbor, in a virtually identical way. The patient remembered the neighbor, a "family friend," taking him into a garage, backing him into a corner, and fondling his genitals.

Prior to the analysis, the patient had never spoken with anyone (including himself) in any depth about the molestation. Neither he nor his brother had told their parents or anyone else about the molestation as it was going on; their "conversation" with one another about it (which occurred some twenty years after the fact) consisted of only a few sentences. Mr. S said that he hated the idea of making a big deal of it, or of being viewed (or viewing himself) as a victim: "The current fashion of everyone's being the victim of child molestation disgusts me." He tried to treat the molestation as "water under the bridge." The sad defensiveness of this posture became evident to Mr. S over the course of the analysis, particularly as he became able to experience the enormous shame he felt over the fact that he had felt sexual excitement (along with feelings of numbness, terror, unreality, and confusion) during the molestation. Mr. S and I came over time to view his combative "stubbornness" as an unconscious effort to maintain his sanity in the face of real and imagined threats to his life, beginning in early

childhood. From this vantage point, his "stubbornness" came to be understood paradoxically as one of the healthiest aspects of his personality, reflecting as it did an unwillingness to submit, to lose himself, or to be crushed by another person's will.

Mr. S's father was a very successful international financier who spent almost all of his time traveling in connection with his business. The patient's mother was a depressed, passive woman who stayed at home "with the children," although she rarely played with them or even spoke to them except in operational ways: "It's time for dinner"; "Don't stay up too late"; "Be sure to brush your teeth." When the patient was two or three, his mother began drinking heavily, and taking tranquilizers prescribed by the family doctor. In one of the sessions leading up to the one in which I made two significant unplanned interventions, Mr. S talked about having spent a great deal of his childhood trying to cheer his mother up by anticipating her needs (for example, by getting her cigarettes or coffee) or by trying to think of ways that he could help her to feel better. "There was always in the background the threat that she would kill herself."

The patient's life as a child (when he was not attending to his mother) was, to a large degree, a life of endless story-making and daydreams, into which he retreated. This state of mind, which served as a substitute for life in the external world and in his body, was unpredictably disrupted by the neighbor's molestation and by the demands posed by his mother's depressed moods and implicit suicidal threats.

With the foregoing very brief overview of the initial years of Mr. S's analysis in mind, I will now turn to a series of sessions that occurred during the fourth year of Mr. S's analysis. In the first of these, I was quieter than usual. Mr. S said, "I can't find you today." The patient was remarkably sensitive to the ebb and flow of my emotional presence during his sessions. It was true that during the initial part of that meeting I had been feeling extremely drowsy and had been fighting off sleep. I said to Mr. S that his description of his efforts, day after day, year after year, to keep his mother alive must have been exhausting. (Being with Mr. S that day had been terribly draining for me, but I did not say that to him since that would have made my psychological state the most important event of the hour, thus replicating the patient's early relationship with his mother. Neither did I say that he was experiencing me as distant and self-absorbed, just as he had experienced his mother. To have done so would have further confused the patient by treating his perception as a projection.) I told Mr. S that I thought I had sought a place to rest during the session—something Mr. S could not afford to do as a child, feeling as he did that his mother's life was in his hands.

Later in that session I said to Mr. S that I thought that he might have stood out as a target for sexual abuse because of what the neighbor knew about his family, or might have discerned of the patient's feeling of having no internal or external adult presence to protect him. His parents were for him nowhere to be found, as I had been earlier in the hour. I was aware even as I was making this

intervention that it felt contrived, even though there may have been some truth to the idea. It seemed to me that I was trying too hard to demonstrate that I was knowledgeable about the circumstances in which child molestation occurs. Mr. S responded to my comment by saying that he guessed that he felt that way as a child, although it was so much a part of life for him that he never would have thought to describe it in that way.

In the next session, Mr. S told me a dream that consisted of a single image: "There was a tall tree that felt menacing. It might even have been able to talk." He connected the feeling in the dream with a feeling he thought he must have had as a child about the "enormous height" of the neighbor compared to his own height. Of course, it occurred to me that the big, ominous tree may have represented not only the large physical and emotional presence of the neighbor, but also his penis. At this moment in the analysis, I decided to stay at the level of the patient's more conscious experience in order not to violate his privacy by seeming to be able to read his mind.

As the patient was telling me his dream, I was reminded that I had been "coincidentally" filled with sadness the previous evening by a set of lines (accompanied by names and dates) drawn on the wall of a bedroom closet in my home. These markings were a record of the increasing heights of my two sons as they grew up. That evening I had been amazed that the earliest marking was only a foot and a half or two feet from the floor. That

lowest line had been drawn when my younger son was only ten months old. It was not the fact that nineteen years had elapsed since the line had been drawn that had so moved me; it was the thought of the utter dependence of that very small child who had needed me to help him stand with his back to the wall so that he could have "his line" drawn. This reverie had a strong sensory component to it and I could feel, almost as a present event, the soft skin of my son's arms and torso as I helped him stand. I said to Mr. S, in response to his dream and my reverie, that when he was molested, he wasn't much taller than the low table near the analytic couch. (Though I was speaking *from* my reverie experience, I was not speaking *about* it [Ogden 1994a, 1997a, b].)

With all this in mind (and in bodily sensation) I met the patient in the waiting room the following day for our session. He seemed unsettled as he walked into my office and lay down on the couch. He began immediately by saying that he was angry with everybody. He was furious with a "dimwit" driver of a car who had stopped in the middle of an intersection and caused a traffic jam. The driver had seemed not to know whether to drive forward or backward, and had "just sat there doing nothing."

It seemed apparent that Mr. S unconsciously (and perhaps to some extent consciously) was experiencing both himself and me as maddeningly ineffectual. I decided not to offer that perception as an interpretation because it seemed to me that the effect of an interpretation (an act of defensive "knowing" on my part) would

have undercut his feeling that I was an impotent, ineffectual analyst and he an ineffectual person. It seemed better for both of us to live with these feelings for a while without trying to dispel them. I found myself thinking about a discussion I had had with a friend about the Internet, in which I had said that I felt that there was such a thing as having too much information. I then recalled not wanting to be told the sex of our second child after the amniocentesis had been performed on my wife. Our first child was a boy, and even though I had no strong wish that the new baby be a girl, I was looking forward to the experience of making room in myself to be the father of a girl, at least for the duration of the pregnancy. That was an experience that I continue to value highly, since the baby was a boy and I will never again have a daughter of my own as I did for those months. Although it has taken quite a lot of words to describe the movement of emotion in this reverie, these thoughts occupied only a few moments of "real time."

After the patient had gone on at some length about a list of grievances he had with various people, and after I had experienced and been affected by my own reveries involving both fears of knowing too much and the experience of knowing more (after the amniocentesis) by knowing less, something changed. The interpretation that had seemed premature and defensive a few minutes earlier, now in a modified and far more specific form, seemed apt. I said to Mr. S that he had mentioned in the past that he felt that I put pressure on him to experience

feelings associated both with the molestation and with the sense he had as a child of being utterly on his own. He had said that to experience these feelings made him feel terrified and out of control. I added that he might be feeling angry at me today for putting him in that position once again. (Only after saying this did I become aware that my choice of words alluded not only to a psychological position, but also to a submissive bodily position.)

Mr. S was silent for a minute or so and then began moving about on the couch in a very agitated way, rolling to one side of the couch and then to the other as if trying to find relief from physical pain, but failing to do so. He told me that he was afraid that he was going crazy and would never recover. He did not know how he could possibly work in this state of mind, and it seemed certain to him that he would lose his job as a result. During the preceding year, the patient had become similarly disorganized and agitated during two or three of our sessions, but the agitation and confusion this time was by far the most intense and prolonged of these experiences. I said to him that I thought that he was experiencing something of what it must have felt like when he was a small boy being molested—a feeling of losing his ability to think and to control his body, of losing all sense of who he is. Mr. S sat up on the edge of the couch and put his head in his hands. He said to himself out loud, "That's a window, that's a plant, that's a rug" (clearly attempting to hold on to external reality).

When he again told me pleadingly that he was terrified that he would never recover from this feeling of going crazy, I spontaneously said to him, "I won't let that happen." I meant this when I said it, although I was aware that I was promising a lot. Mr. S quieted a little and lay back down on the couch trembling. I kept talking to him so that he would know I was there. I said to Mr. S, "Imagine what it would be like if you, at your present age, were taken without warning into a corner and had your genitals fondled by a man who was as big as a tree. And you would have every reason to believe that this would happen unexpectedly at any time again and again for the rest of your life. And you wouldn't be allowed to tell anybody about it ever. That's more than any boy or any man can possibly take in or live with." (I was aware that I was using the experience of the sexual molestation as a symbol for a large conglomeration of experiences of neglect and overstimulation that Mr. S had experienced both during and between the episodes of molestation, and in his "privileged" role as his mother's guardian and confidant.)

The patient's body, which had been contorted and twisted on the couch, now visibly relaxed. He said that his head felt calm and his body felt "wired . . . no, that's not the right word . . . it feels jazzed."

I said, "It is as if what was going on in your head has been downloaded into your body." He laughed with delight and said, "Yes, but in downloading it, it changed. It feels like something entirely different from what had been in my head. My body feels tingly. . . . no, that's not it either. It's just that I feel my body's being there. I almost never feel that I have a body. It's a curious feeling, I like it." Later that day he left a phone message saying that he felt better and that he felt very grateful to me.

Mr. S began the next session by saying that as he walked to my office he thought that what he'd like to do is lie down on my couch and sleep. He then said that this wish felt connected with a dream that he had had the previous night. "In the dream I was supposed to analyze a baby. I wasn't sure what that meant or how I would go about doing it. I walked into the baby's room and saw the baby sleeping in his crib. I lay down on a bed next to the crib and we slept. Then a man came in. He looked like the pediatrician I had as a kid. I liked him but even though it looked like him I knew it was you. He just watched the baby and me sleeping for a while and then he left."

I said to Mr. S that he had told me how as a child he was continually trying to figure out ways to make his mother feel better and to get his parents to like one another more. He could never just go to sleep and leave it to them to figure out what was happening and what to do about it. I said that at least as the baby and as himself in the dream, and maybe at times with me in our sessions, he can just leave it to me to know what is going on so he can sleep peacefully (knowing I am looking in on him to make sure everything is okay). Mr. S responded by saying that he had been able to jog today in a way that felt different. In the past the feeling in his legs would frighten him and he would stop after a very short time. "Today I felt all the fatigue in my legs. It

wasn't that horrible feeling of being overwhelmed. Like the feeling I had on the couch at the end of last session, it was interesting."

Discussion

The fragments of the sessions just presented are not meant as models of analytic work with patients who have defensively created a disjunction between their minds and their bodies. Rather, I am attempting to talk to myself and to the reader about ways I found myself feeling and intervening that were surprising to me and that seemed to have been of value to this patient. To borrow the patient's words, I found myself feeling and behaving in ways that were curious and interesting to me.

Mr. S had spoken in an agitated way at the beginning of the session in which I made the two interventions that surprised me. He was furious at a "dimwit driver" who seemed to be paralyzed in a situation that he found overwhelming. The patient's disowned identification with the driver, and his displaced anger at me, were palpable in the room. Mr. S seemed to be frantically warding off his own feelings of confusion and helplessness. At first in that session I was unconsciously identifying with Mr. S in my efforts to defend myself against the full experience of being confused and flooded. I adopted the somewhat detached and contrived stance of the enlightened, knowledgeable psychoanalyst familiar with matters concerning child molestation.

It was necessary in that session, if any psychological work was to be done, for me to be able to "come to my senses," both in the sense of understanding what was going on, and perhaps even more important, in the sense of being able to live in, and speak from, my experience of my bodily sensations. This was an essential precondition for the patient's development of his own capacity to "come to his senses": to come to life in a physical/emotional/cognitive way. My own psychological work was done to a large extent in the medium of my reverie about helping my ten-month-old son to stand with his back to the wall of the closet so that his height could be recorded. The diabolical nature of the patient's "back to the wall" experience was made painfully and sadly real for me in an immediate sensory way as I unconsciously juxtaposed it with the loving "back to the wall" experience with my younger son. The measuring and the drawing of "permanent" markings on the wall were part of a family rite (with a living emotional/physical history) in which we all took pleasure. The tactile component of the reverie involved a sensory experience of the softness of my son's skin as I helped him stand up to be measured. It was from the sadness of this physically alive reverie that I said to Mr. S that when the molestation occurred he had been no taller than the table near the analytic couch.

It was only as I became increasingly able to be present in this sensory/emotional way that I could be more fully responsive to the patient's terror that he would never recover his sanity. It seems to me in retrospect that one

of the most significant outcomes of having come more fully to my senses was my statement to the patient at the height of his fear of permanently going mad: "I won't let that happen." This was a spontaneous ("unminded") statement of a sort that I had never before made to Mr. S. It did not feel like a reassurance (which is a way of minimizing, and thus of refusing to join with the patient in an effort to face and to develop understandings of his psychic pain). Rather, it felt like a statement that I was making not only as a (transference-countertransference) parent, but as an analyst taking responsibility for the thinking and the clinical judgments that are part and parcel of analytic work with a patient struggling with psychotic-level anxiety and feelings of impending disintegration. My willingness to take on that responsibility seemed to facilitate the patient's capacity to experience the full intensity of his feelings. It was my responsibility to provide a reliable setting that ensured the patient's physical and psychological survival during this period of imminent fragmentation. I would not have made such a statement if I did not believe that as a consequence of my training and experience, I could provide the necessary physical and emotional presence during the hour, and in the days and months to follow. There is a very important practical aspect of providing an adequate analytic framework when working with patients on the edge of psychotic fragmentation. I had to know that I was both willing and able to be available to meet with the patient (both metaphorically and literally) as needed. (Meeting six or seven days a week for more than a year at a time

have been necessary and extremely productive parts of my analytic work with other patients.)[1]

A second aspect of this session that seems to warrant examination was my asking the patient (again in an unplanned way) to imagine how his molestation experiences would feel at his present age. Although I have worked with many patients who experienced childhood sexual abuse, until the moment I made this intervention it had never occurred to me to imagine myself as an adult, and to ask the patient to imagine himself as an adult, into the eerily everyday quality of the molestation experience.

As I look back on the telling of this story and my invitation to the patient to be part of it, the experience seems to have served a number of physical/psychological functions. The sound of my voice speaking at some length was itself a form of (emotional/sensory) compassionate presence that was vital at that juncture. I was accompanying the patient psychologically (by inventing a story based on his experience) and physically (through the sound and feel of my voice) into the imagined scene. It was apparent to me, and I think to the patient, that I was

1. I do not believe that I could spontaneously have said to the patient, "I won't let that happen," had I not spent many years reading and rereading Winnicott's papers on the psyche-soma (1949) and the role of regression in the analytic process (1954). I am thinking in particular of the clinical vignette in which he says: "the patient became able to accept the not-knowing condition because I was [metaphorically] holding her and keeping a continuity by my own breathing while she let go, gave in, knew nothing" (1949, p. 252).

not only imagining the patient into the scene I was describing, but imagining myself into it as well, both in the sense of identifying with him, and in the sense of introducing myself as a third figure bearing witness (and bearing language, secondary-process thinking, and compassion).

The patient calmed in response to my invitation to enter imaginatively into this story with me; his bodily contortions gave way to a visibly relaxed muscular state. Mr. S said that his head felt peaceful. He searched for a word to describe his bodily sensations and at first settled for the word "jazzed." I then introduced a somewhat whimsical and quite flawed metaphor in which I likened the transformation of feeling that Mr. S had just experienced to the downloading of computer data from his head into his body. Mr. S laughed with obvious pleasure, which in itself was an extremely rare event in the analysis. He went on to correct my weak metaphor: after trying out a number of descriptive words that he felt incorrectly described his bodily experience, he said that it was just that he could feel that his body was there and that it was a curious and interesting feeling, a feeling he liked.

Mr. S began the next session with his offhand comment about wanting to sleep on my couch, and then with his dream, which ended: "I lay down on a bed next to the crib and we slept." I was struck by the simplicity and tenderness of the words "we slept"—not "I went to sleep," or "I slept next to the baby," but "we slept." In putting it in this way, Mr. S unselfconsciously captured a quality of the analytic relationship at that point in the work: a feeling of one sleep (one "dream/reverie space") shared by

two separate people. The dream ended with the image of a man coming into the room who looked like his childhood pediatrician but whom he knew, even in the dream, to be me. The man looked on for a while, making sure everything was okay, and then left. My interpretation of the dream addressed the patient's feeling that in contrast to the vigilant "mindedness" that had occupied so much of his life from early childhood onward, he could (in the dream, and sometimes in the sessions with me) "just sleep," leaving it to me to make sure everything is okay. Mr. S responded in a way that led me to feel that he was ahead of me (as he had been earlier when he corrected my "downloading" metaphor). He responded with an account of being able to jog without fear of being overwhelmed by bodily sensation. This apparent non sequitur seemed to me to be his unconscious way of saying to both of us that not having to figure it out, "just sleeping," was an important experience for him in its own right, and at the same time made possible something further: a feeling-level "knowing" that he has a body—not a body as idea or image, but a body alive with sensations such as the feeling of fatigue in his legs as he jogs.

In sum, I have presented fragments of an analysis in an effort to consider the origins and effects of two interventions that came as a surprise to me. The first of these ("I won't let that happen") involved speaking from a form of "I-ness" (reflected in the voice with which I spoke) that was new to me. It was a parental voice that took on the responsibility of protectively "minding" the patient while he was in a state of imminent psychotic fragmentation.

The second intervention involved my spontaneously inviting the patient to imagine himself into a story of molestation (based on his history and the history of the analysis) in which I was a third presence bearing witness, bearing language, and bearing compassion. Both interventions seemed to have had important consequences for the progress of the analysis. My spontaneous responses to the patient's psychotic-level anxiety and feelings of impending psychic disintegration seem to have contributed to a process in which he developed a greater sense of being alive in the experience of a coextensive minded body[2] and bodied mind.

2. I am grateful to Dr. Gloria Burk for the phrase "minded body." I find the term particularly apt not only for the way it locates the mind as an aspect of the body, but also for how it alludes to the infant's experience, when things are going well, of being "minded" (physically and emotionally cared for) by the mother over time.

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An Elegy, a Love Song, and a Lullaby